STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155582		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	X3) DATE SURVEY COMPLETED 05/22/2012	
	PROVIDER OR SUPPLIE		STREET A	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST RUSA, IN 46573	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0000	and State Licer conducted by Department of accordance wire Survey Date: (Code Specialis)  At this Life Saf Miller's Merry not in complia Requirements Medicare/Med Subpart 483.7 from Fire and the National Fi Association (N Code (LSC), Ch Health Care Oci IAC 16.2.	th 42 CFR 483.70(a).  25/22/12  2r: 000521  2er: 155582 100266980  2 Kelley, Life Safety t  2ety Code survey, Manor was found nce with for Participation in icaid, 42 CFR 0(a), Life Safety the 2000 edition of re Protection FPA) 101, Life Safety iapter 19, Existing accupancies and 410  facility was be of Type V (000)	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000521

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 06/11/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number:  155582	(X2) MULTIPLE CON  A. BUILDING  B. WING	01	COMPLETED 05/22/2012
	PROVIDER OR SUPPLIER S MERRY MANOR	300 N W	DDRESS, CITY, STATE, ZIP CODE /ASHINGTON ST USA, IN 46573	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION
	sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and single station battery operated smoke detectors in the resident rooms. The facility has a capacity of 133 and had a census of 117 at the time of this survey.  Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/25/11.  The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 2 of 22

			X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	A. BUILDING 01 C	
		155582	B. WING		05/22/2012
	PROVIDER OR SUPPLIE S MERRY MANOR		300 N \	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST RUSA, IN 46573	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K0018 SS=E	Doors protecting than required er exits, or hazard doors, such as the solid-bonded coresisting fire for sprinklered build resist the passa impediment to the Doors are provious keeping the door meeting 19.3.6.  Roller latches a regulations in all Based on obseinterview, the ensure there we to the closing area corridor opening practice could in the Beauty State Director's office Director of Nutrice and the same corridor of State of S	facility failed to vere no impediments of 3 of 14 service doors protecting ngs. This deficient affect any residents shop, the Executive and the Assistant rsing (ADON) office.  de:  rvation with the upervisor 05/22/12  to 3:00 p.m., the to the Beauty Shop,	K0018	The kick down door stops wer removed from the Beauty Sho ADON Office & Executive Director doors by 5/24/12. No residents were affected by this deficiency. Any residents loca in the Beauty Shop, ADON Of or Executive Director's office could have been affecte by this deficiency. An all staff inservice was conducted on 6/7/12 to remind staff to not prany facility door for any reason any time. A Quality Assurance Tool (Attachment A) will be us 3 times per week for 4 weeks, then 1 time per week thereafte to ensure that office doors are propped ongoing. The Maintenance Supervisor, or designee, will be responsible.	rop n at esed

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet Page 3 of 22

PRINTED: 06/11/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155582	(X2) MULTIPLE CO  A. BUILDING  B. WING	01	(X3) DATE SURVEY COMPLETED 05/22/2012
	PROVIDER OR SUPPLIER  S MERRY MANOR	300 N V	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST RUSA, IN 46573	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
	stop. This was acknowledged by the Maintenance Supervisor at the time of observations.			
	3.1–19(b)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 4 of 22

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 01			COMPLETED	
		155582	B. WIN	G		05/22/	2012	
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
					WASHINGTON ST			
MILLER'S	S MERRY MANOR			WAKAF	RUSA, IN 46573			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG K0021	NFPA 101	LSC IDENTIFYING INFORMATION)		TAG	DEI (CLERCI)		DATE	
SS=E	-	ODE STANDARD						
00 2		xit passageway, stairway						
		ontal exit, smoke barrier or				ļ		
		enclosure is held open only						
		ged to automatically close all one or throughout the facility						
	upon activation of							
	a) the required n	nanual fire alarm system;						
	b) local smoke d	etectors designed to detect				ļ		
		hrough the opening or a				ļ		
	required smoke	detection system; and						
	c) the automatic 19.2.2.2.6, 7.2.1	sprinkler system, if installed. 1.8.2						
	1. Based on ob	oservation and	K00	021	The kick down door stops loca		06/21/2012	
	interview, the f	acility failed to			on the 2 kitchen corridor doors were removed by 5/24/12. The			
	ensure 2 of 2 k	itchen corridor			rubber door wedges located at			
	doors were hel	d open only by a			the single fire doors leading to			
	device which w	ould allow it to			Assisted Living Facility were			
	close automati	cally upon			removed on 5/22/12. No reside were affected by this deficience			
	activation of th	e fire alarm system.			Any residents located in the m	•		
	This deficient p	oractice could affect			dining room or rehab unit could	d		
	any in the mair	n dining room.			have been affected by this	and		
					deficiency. A quote was obtain by Safe Care (Attachment B) t			
	Findings includ	le:			add 2 magnetic door holds to to 2 kitchen corridor doors so that			
	Based on obse	rvation with the			these doors will remain open			
	Maintenance Su				unless our fire system is activated, which would then			
	05/22/12 at 2:				release the doors to close			
		leading into the			automatically in the event of a			
		quipped with kick			fire. An all staff inservice was	_		
	down door sto				conducted on 6/7/12 to remind			
	·	by the Maintenance			staff to not prop any facility do for any reason at any time. A	וט		
	Supervisor at the	•			Quality Assurance Tool			
	j bupervisor at ti	ווכ נוווופ טו	- 1		1		I	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 5 of 22

	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JETIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	
		155582	B. WINC	3		05/22/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	NO VIDEN ON SOLVEIEN			300 N V	VASHINGTON ST		
MILLER'S	S MERRY MANOR			WAKAR	RUSA, IN 46573		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	observation.				(Attachment A) will be used 3		
					times per week for 4 weeks, the 1 time per week thereafter, to	ieri	
	3.1-19(b)				ensure that the kitchen & exit		
					doors leading to the Assisted		
	2. Based on ob	servation and			Living Facility are not propped		
	interview, the f	acility failed to			ongoing. The Maintenance	_	
	ensure 2 of 2 h	orizontal exit			Supervisor, or designee, will b responsible.	е	
	single fire door	rs were held open			respondible.		
	only by a devic	e which would					
	allow it to close	e automatically					
		of the fire alarm					
	· •	eficient practice					
	could affect an	•					
	evacuated thro	•					
		nall exit in the event					
	of a fire emerg						
	or a fire efficiency	ency.					
	Findings includ	le:					
	Rased on obser	vation with the					
	Maintenance Su						
	05/22/12 at 1:	•					
		rs leading to the					
	Assisted Living						
	_	<del>-</del>					
	1	with a rubber door					
	_	as acknowledged					
		ance Supervisor at					
	the time of obs	servation.					
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 6 of 22

PRINTED: 06/11/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155582		LDING	01	(X3) DATE : COMPL <b>05/22</b> /	ETED
	PROVIDER OR SUPPLIER S MERRY MANOR			300 N V	ADDRESS, CITY, STATE, ZIP CODE VASHINGTON ST RUSA, IN 46573		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0038 SS=E	Exit access is an readily accessible with section 7.1.  1. Based on obinterview, the fensure the meathrough 2 of 9 accessible for relinical diagnoss specialized sector LSC 19.2.2.4 within a require shall not be equivered or lock that rectool or key from Exception No. locking arranged delayed egress in health care opportions of head occupancies, where their safety, progreadily unlock stimes. This decould affect an medical diagnormal in the sector of the sector	eservation and acility failed to ans of egress exits were readily esidents without a sis requiring urity measures. requires doors ed means of egress uipped with a latch quires the use of a means of egress side. I requires door ements without shall be permitted occupancies, or alth care here the clinical sidents require urity measures for exidents require urity measures for exided staff can such doors at all ficient practice y resident without a uses requiring res exiting through on and	K00	038	Codes were posted at the Rehabilitation Hall & Maintena Hall exit doors by 5/25/12. No residents were affected by this deficiency. Any resident trying exit the facility at the Rehabilitation Hall & Maintena Hall exit doors could have bee affected by this deficiency. An staff inservice was conducted 6/7/12 to inform staff that code were now posted at the Rehabilitation Hall & Maintena Hall exit doors. No further corrective action or monitoring be necessary as this solution of permanently resolve this issue its entirety. The spare wheelch were removed from the Maintenance Shop Exit Corrid by 5/23/12. The 2 hand carts were moved down the hall towards the dining room by 5/23/12 to not interfere with the exit located within the Maintenance Shop Corridor. No residents were affected by this deficiency. Any residents being evacuated through the Maintenance Shop Corridor Ecould have been affected by the deficiency. An all staff inservice was conducted on 6/7/12 to remind staff to not place any wheelchairs, or other items, in Maintenance Shop Corridor at any time in the future and to keep the staff in the future and to keep the form of the form	s to  ince in all on es ince j will e in airs or e s g ixit his e the	06/21/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 7 of 22

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED	
		155582	B. WIN			05/22/2012	
NAME OF B	DROWINED OR CLIDDLIED		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			300 N V	VASHINGTON ST		
MILLER'S	S MERRY MANOR			WAKAF	RUSA, IN 46573		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E COMPLET	
TAG		LSC IDENTIFYING INFORMATION)		TAG	,	DATE	
	Findings includ	le:			the hand carts located in their current position ongoing. A		
					Quality Assurance Tool		
	Based on obser	vation with the			(Attachment A) will be used 3		
	Maintenance Sı	upervisor on			times per week for 4 weeks, th	en	
	05/22/12 duri	ng the tour from			1 time per week thereafter, to		
	1:35 p.m. to 1:	<del>-</del>			ensure that the no wheelchairs other items, & hand carts are i		
	Rehabilitation I	•			their proper location ongoing.		
		all exit doors were			Maintenance Supervisor, or		
		cked and could be			designee, will be responsible.		
	-						
	· ·						
		•					
		•					
	was not aware	of this requirement.					
	3.1-19(b)						
	2. Based on ob	oservation and					
	interview, the f	acility failed to					
	ensure egress	for 1 of 5 exit					
	corridors was r	not used for					
	storage. LSC 7	.1.3.2.3 requires an					
	_	shall not be used					
	for any purpos	e with the potential					
		-					
		•					
		=					
	_	·					
	I						
		_					
	i maintenance si	nop corridor.					
	opened by enterthe code was not aware  3.1–19(b)  2. Based on obinterview, the fensure egress for any purpose to interfere wit LSC 7.1.10.1 "National be continuous tructions or full instant use other emergendeficient practi	ering a code, but ot posted. The upervisor stated he of this requirement.  Deservation and facility failed to for 1 of 5 exit mot used for 1.1.3.2.3 requires an shall not be used with the potential h its use as an exit. Means of egress uously free of all r impediments to in case of fire or cy use." This ce affects any ated through the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 8 of 22

PRINTED: 06/11/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	01	(X3) DATE SURVEY  COMPLETED
	155582	A. BUILDING B. WING		05/22/2012
	ROVIDER OR SUPPLIER	300 N V	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST	
	S MERRY MANOR		RUSA, IN 46573	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	Findings include:			
	Based on observation with the Maintenance Supervisor on 05/22/12 at 1:10 p.m., the egress path in the maintenance shop exit corridor was used for storage of spare wheelchairs and two hand carts. Based on an interview with the Maintenance Supervisor at the time of observation, he said this was the permanent storage area for spare wheel chairs.  3.1–(19)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 9 of 22

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155582		LDING	ONSTRUCTION  01	(X3) DATE : COMPL <b>05/22</b> /	ETED
	PROVIDER OR SUPPLIER			300 N \	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST RUSA, IN 46573		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0048 SS=B	There is a written patients and for of an emergency.  Based on recordinterview, the five provide a written included the use fire extinguished fire plans. LSC written health of safety plan that the following:  (1) Use of alarm (2) Transmission fire department  (3) Response to (4) Isolation of (5) Evacuation of (6) Evacuation of (7) Preparation building for evaluation for evaluati	d review and acility failed to en plan that se of the K-Class er in 1 of 1 written 19.7.2.2 requires a care occupancy fire t shall provide for ensor of alarm to the to alarms fire of immediate area of smoke of floors and acuation ment of fire oractice could affect and staff in and near the event of an	K00	)48	We believe that it is important note that the facility did provid written plan that included the of the K-Class fire extinguished copies were present in the State 2 Nurses Station & Maintenant Supervisor's Disaster Manuals upon inspection on 5/22/12. Furthermore, the facility does acknowledge that there was noted to copy of this policy located in the Executive Director's Disaster Manual upon inspection on 5/22/12. No residents were affected by this deficiency. An residents located near the kitch during an emergency could have been affected by this deficiency. A copy of the written plan including the use of the K-Clastire extinguisher was placed in Executive Director's Disaster Manual by 5/23/12 (Attachmet C). The Executive Director will responsible to ensure that this policy remains in the Executiv Director's copy of the Disaster Manual ongoing & this manual be reviewed on an annual base.	e a use use r & ation ce s ot a ne  y then ave cy. ss n the l be s e	06/21/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 10 of 22

PRINTED: 06/11/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION  OF CORRECTION  155582	(X2) MULTIPLE CO  A. BUILDING  B. WING	01	(X3) DATE SURVEY COMPLETED 05/22/2012
	PROVIDER OR SUPPLIER S MERRY MANOR	300 N V	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST RUSA, IN 46573	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION
	05/22/12 at 12:18 p.m., the "Disaster Manual" did not address the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. Based on an interview with the Maintenance Supervisor at the time of record review, this was the copy of the Disaster Manual from the Executive Director's office.  3.1–19(b)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 11 of 22

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155582	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 05/22/2012
	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST RUSA, IN 46573	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0056 SS=E	If there is an autoinstalled in accordance wit Standard for the Systems, to provportions of the biproperly maintain 25, Standard for Maintenance of Systems. It is fureliable, adequat system. Require equipped with was witches, which the building fire at 1. Based on obtinterview, the fensure complete sprinkler system 1 of 1 electrical heater/sprinkler system 1 of 1 electrical heater/sprinkler system of the building practice could accordance wit Standard for the Sprinkler System complete cover of the building practice could an ear the Station Findings include Based on obsermance Standard for obsermance Standard for obsermance Standard for the Station Findings include Based on obsermance Standard for observations for observation for obs	oservation and acility failed to the automatic of was provided for lowater of the riser rooms in the NFPA 13, the lost lower of the low	K0056	On 6/5/12, Safe Care remove sealed off 1 of the 3 sprinker heads located in the Inservice Director's office, thu eliminating the concern with having 2 of the 3 sprinkler heal located 30 inches apart or wit 6 feet of each other (Attachme D). Furthermore, on 6/5/12, S Care added 2 sprinker heads the electrical/water heater/sprinkler riser room, the eliminating the concern with in having an automatic sprinkler system in this room (Attachme D). No residents were affected this deficiency. Any residents located in the Inservice Direct office or near the Station 1 Nurses Station could have be affected in the event of a fire emergency related to this deficiency. No further correctinaction or monitoring will be necessary as this solution will permanently resolve this issue	s ads hin ent afe in us ot ent d by or's en

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet Page 12 of 22

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLI	
155582		B. WIN	IG		05/22/2	2012	
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
			300 N WASHINGTON ST				
MILLER'S	S MERRY MANOR			WAKAF	RUSA, IN 46573		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	FIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	riser room lack	·			its entirety.		
	_	was acknowledged					
		ance Supervisor at					
	the time of obs	servation.					
	3.1-19(b)						
	2. Based on ob	oservation and					
	interview, the f	acility failed to					
	ensure 2 of 3 s	prinkler heads in					
	the Inservice D	irector's office were					
	separated by a	t least six feet as					
	required by NF	PA 13. NFPA 13					
	Section 5-6.3.4	4 requires					
		ocated no closer					
	_ ·	easured on center.					
		practice could affect					
	any resident in						
	<u> </u>	e in the event of a					
	fire emergency						
	in a cinci gana,						
	   Findings includ	le <sup>.</sup>					
	i mamga melaa						
	Based on obse	rvation with the					
	Maintenance Si						
		:00 p.m., two of					
	three sprinkler						
	· ·	tor's office were					
		nches apart. This					
	was acknowled						
		upervisor at the					
	time of observa	ation.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 13 of 22

PRINTED: 06/11/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  05/22/2012			
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE  300 N WASHINGTON ST  WAKARUSA, IN 46573				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet Page 14 of 22

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  O1			(X3) DATE SURVEY COMPLETED	
I I I DI LINI	o. condenon	155582	A. BUILDING 05/22/20				
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				WASHINGTON ST		
	S MERRY MANOR			WAKAF	RUSA, IN 46573		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	COMPLETION DATE
K0072	NFPA 101	ESC IDENTIF TING INFORMATION)	+	170			DATE
SS=E	-	ODE STANDARD					
	free of all obstrue instant use in the emergency. No	are continuously maintained ctions or impediments to full e case of fire or other furnishings, decorations, or struct exits, access to, visibility of exits. 7.1.10					
	Based on obser	-	K00	72	No residents were affected by	this	06/21/2012
	interview, the f				deficiency. Any residents being		
	•	ishings, decorations			evacuated through the main	£	
		<del>-</del>	dining room exit in the event emergency had the potential				
	or other objects were placed as to obstruct exits for 1 of 9 exits.  This deficient practice could affect				be affected by this deficiency.		
					The Maintenance Supervisor		
		evacuated through			removed the lawn furniture		
	•	g room exit in the			obstructing the exterior exit discharge path for the main dir	nina	
					room on 5/22/12. An all staff	9	
	event of an emergency.  Findings include:				inservice was conducted on 6/7/12 to remind staff to not facility exits or exterior sidew at any time in the future. A		
	Based on obser	vation with the			quote from Huff Construction (Attachment E) was obtained t	0	
	Maintenance Sı	upervisor on			install an additional 5' x 23' par		
	05/22/12 at 1:	20 p.m., the			of concrete leading directly fro	m	
	exterior exit di	scharge path for			the main dining room exit	ot	
	the main dining	g room exit is			discharge path to the parking I located at the rear of the facilit		
	obstructed by I	awn furniture.			which will bypass the area who		
	Based on an int	terview with the			the lawn furniture is normally		
	Maintenance Sı	upervisor at the			located. A Quality Assurance (Attachment A) will be used 3	l ool	
	time of observa	ation, the main			times per week for 4 weeks, th	ien	
	dining room ex	rit discharge path			1 time per week thereafter, to		
	was obstructed	by two metal			ensure that the exterior exit		
	chairs and a m	etal bench.			discharge path for the main dir room is not obstructed by any	ning	
	chairs and a metal bench.  3.1–19(b)				objects in the future. The Maintenance Supervisor, or designee, will be responsible.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 15 of 22

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	01	COMPL		
155582		B. WIN	G		05/22/	2012	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 300 N WASHINGTON ST WAKARUSA, IN 46573				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0076 SS=D	Medical gas stor are protected in Standards for He	ODE STANDARD age and administration areas accordance with NFPA 99, ealth Care Facilities.					
	3,000 cu.ft. are e separation.	ge locations of greater than enclosed by a one-hour					
	than 3,000 cu.ft. NFPA 99 4.3.1.1						0.5/0.1/0.010
	the Station 2 m properly restra Section 8–3.1.1 cylinder restrai requirements of 4–3.5.2.1(b) 27 freestanding cy chained or sup stand or cart. practice could a near the Station room. Findings include Based on an ob- Maintenance St 05/22/12 at 1:	acility failed to exygen cylinders in edication room was ined. NFPA 99, 11.2(h) requires nt to meet the of Section 7 which requires vlinders to be ported in a cylinder This deficient affect any staff in or n 2 medication  de:	K00	076	The E cylinder oxygen tank waremoved from the Station 2 Medication Room on 5/22/12 to the Maintenance Supervisor. A residents were affected by this deficiency. Any resident locate near the Station 2 Medication Room could have been potent affected by this deficiency. An staff inservice was conducted 6/7/12 to remind nursing staff not store any E cylinder oxyge tanks in the Station 2 Medicati Room & to only store them in the proper location ongoing. A Quantum Assurance Tool (Attachment A will be used 3 times per week 4 weeks, then 1 time per week thereafter, to ensure that E cylinder oxygen tanks are not stored in the Station 2 Medicati Room ongoing. The Maintenan Supervisor, or designee, will be responsible.	oy No ad ially all on to on the ality for	06/21/2012
		rygen in the Station					
	Compressed ox	ygen in the station	ı				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 16 of 22

PRINTED: 06/11/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 05/22/2012			
MILLER'S	PROVIDER OR SUPPLIER S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 300 N WASHINGTON ST WAKARUSA, IN 46573				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
		oom. This was by the Maintenance he time of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet Page 17 of 22

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPL		
155582		B. WIN	G		05/22/	2012	
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 300 N WASHINGTON ST WAKARUSA, IN 46573				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0154 SS=C	Where a required is out of service is out of service is 24-hour period, the jurisdiction is not evacuated or an is provided for all the shutdown unbeen returned to Based on recording a compolicy containing followed in the automatic spring be placed out of than 4 hours in in accordance with a sprinkler impairs comply with NF Inspection, Tes Maintenance of Protection Systems of a sprinkler impairs of a sprinkler impairs of a sprinkler in a watch and 11-local fire deparron of a sprinkler in a sprinkler in a sprinkler in a sprinkler in a sprinkler impairs of a sprinkler in a sprinkler impairs of a sprinkler in a sprin	d review and facility failed to 117 residents by implete writtening procedures to be event the inkler system has to of service for more in a 24 hour period with LSC, Section 1.7.6.2 requires rment procedures FPA 25, Standard for ting and if Water Based Fire ems. NFPA 25, an appointed rment coordinator. requires a ogram to include an approved fire 5(d) requires the tment be notified	K0)	154	We believe that is important to note that the facility did provide complete written policy contain procedures to be followed in the event the automatic sprinkler system were to be out of service for more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1 as copies were present in the Station 2 Nurses Station & Maintenance Supervisor's Disaster Manuals upon inspection on 5/22/12. Furthermore, the facility does acknowlege that there was not copy of this policy located in the Executive Director's Disaster Manual. No residents were affected by this deficiency. All facility residents had the potent to be affected by this deficiency. A copy of the written plan for of "Fire Watch" policy (Attachment G), was added to Executive Director's copy of the Disaster Manual on 5/24/12. Texecutive Director will be responsible to ensure that this policy remains in the Executive Director's copy of the Disaster Manual ongoing & this manual	e a ning ne ce n s s e s a a e e stial cy. The e he e e	06/21/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 18 of 22

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155582		(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 05/22/2012				
	NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE  300 N WASHINGTON ST  WAKARUSA, IN 46573					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)					
	carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11–5(f) requires notification of supervisors in the area in addition to those already mentioned and lastly 11–7 requires notification of everyone again when the system is restored. This deficient practice could affect all occupants.  Findings include:  Based on review of the "Fire Watch Policy and Procedure" policy with the Maintenance Supervisor on 05/22/12 at 12:22 p.m., the facility did have a written policy and procedure for an impaired sprinkler system available for review, but it did not address the following:  a) the designated person(s) shall be trained b) the local fire department must be notified Based on interview with the Maintenance Supervisor at the time of record review, it was acknowledged the Executive Director's fire watch policy did not include the aforementioned items.		be reviewed on an annual ba	asis.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 19 of 22

PRINTED: 06/11/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155582  AND PLAN OF CORRECTION  A. BUILDING  B. WING	COMPLETED 05/22/2012
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR  STREET ADDRESS, CITY, STA  300 N WASHINGTON S  WAKARUSA, IN 46573	ST
DREETY CEACH DEFICIENCY MIIST BE DEPCEDED BY FILL DREETY (EACH CORRECTIVE)	PLAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE CICIENCY)  (X5)  COMPLETION DATE
3.1-19(b)	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 20 of 22

PRINTED: 06/11/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155582		(X2) MU A. BUII B. WIN	DING	01	(X3) DATE : COMPL <b>05/22</b> /	ETED	
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE  300 N WASHINGTON ST  WAKARUSA, IN 46573				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K0155 SS=C	Where a required service for more period, the author notified, and the approved fire was left unprotected by alarm system hay 6.1.8  Based on recompliance of the provide a complete for the protection of service for form a 24 hour period with LSC, Section 19.7.1.1 required care occupancy and available to personnel a play protection of alarm system hay for the protection of alarm system hay a service for form a 24 hour period with LSC, Section 19.7.1.1 required and available to personnel a play protection of alarm system hay a service for form a 24 hour personnel a play protection of alarms of the protection of alarms and available to personnel a play protection of	acility failed to plete written policy on of 117 of 117 ating procedures to the event the fire as to be placed out our hours or more criod in accordance on 9.6.1.8. LSC, es every health of to have in effect of all supervisory on for the all periodically be kept informed with of duties under the disions of 19.7.1.2 a.3 shall apply. es all fire safety e for the use of asmission of the e department and	K01	55	We believe that is important to note that the facility did provide complete written policy contain procedures to be followed in the event the automatic sprinkler system were to be out of servifor more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1 as copies were present in the Station 2 Nurses Station & Maintenance Supervisor's Disaster Manuals upon inspection on 5/22/12. Furthermore, the facility does acknowlege that there was not copy of this policy located in the Executive Director's Disaster Manual. No residents were affected by this deficiency. All facility residents had the potent obe affected by this deficiency. A copy of the written plan for compact of the wri	e a hing he ce ce ce contact a la ce ce contact a la ce ce contact a la ce ce ce contact a la ce	06/21/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 21 of 22

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155582	(X2) MULTI A. BUILDIN B. WING		01	(X3) DATE ( COMPL <b>05/22</b> /	ETED
NAME OF PROVIDER OR SUPPLIER  MILLER'S MERRY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 300 N WASHINGTON ST WAKARUSA, IN 46573				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			O FIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	be instructed in phrase to assure the alarm during the building firm. This deficient procedure.  Findings included Based on review Policy and Procedure alarm system a but it did not a following:  a) the designate be trained by the local fire be notified Based on intervention and procedure alarm system a but it did not a following:  a) the designate be trained by the local fire be notified Based on intervention and procedure alarm system a but it did not a following:  a) the designate be trained by the local fire be notified Based on intervention and procedure alarm system and but it did not a following:  a) the designate be trained by the local fire be notified Based on intervention and procedure acknowledged Director's fire well as the procedure and procedure alarm system and procedure alarm	w of the "Fire Watch edure" policy with the Supervisor on 2:22 p.m., the e a written policy for an impaired fire vailable for review, ddress the ed person(s) shall department must view with the upervisor at the review, it was			be reviewed on an annual bas	is.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G5TK21

Facility ID: 000521

If continuation sheet

Page 22 of 22